

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02921

2923

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Delaware</b> b. COUNTY <b>Sussex</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg</b>		c. LENGTH OF STAY IN 1b <b>none</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seaford</b> <b>46X-3</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>rural</b>			d. STREET ADDRESS <b>rural</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>George Robert Burton</b>			4. DATE OF DEATH Month <b>March</b> Day <b>7</b> Year <b>1959</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 1, 1934</b>		9. AGE (In years last birthday) <b>24</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>truck driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>trucking</b>		11. BIRTHPLACE (State or foreign country) <b>Seaford, Del.</b>	
13. FATHER'S NAME <b>Verl T. Burton</b>			14. MOTHER'S MAIDEN NAME <b>Samantha Drumm</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes</b>		16. SOCIAL SECURITY NO. <b>221-20-6004</b>		17. INFORMANT <b>Mrs. V. T. Burton, Seaford, Del.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured Skull</b> 825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Automobile accident</b>			
20c. TIME OF INJURY Month. Day. Year Hour a. m. <b>8-7</b> p. m. <b>1959</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>	
		20f. (City or town) <b>Federalsburg</b>		20g. (County) <b>Caroline</b>	
21. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Dawson O. George</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>3-8-59</b>	
EXAMINER'S NAME (Type) <b>Dawson O. George</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>3/11/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Odd Fellows Cemetery</b>	
				22d. LOCATION (City, town, or county) (State) <b>Seaford, Del.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harvey W. Williams</b>			ADDRESS <b>Federalsburg, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 10 '59</b>
					24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE  
DEPT

MISSISSIPPI STATE DEPARTMENT OF HEALTH - BIRTH DEATH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, date, time, place, and cause of death. The form is oriented horizontally but contains vertical text on the left side.

Vertical text on the left side (likely bleed-through from the reverse side):

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# 1 8 M 00 1 0 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. VS A15 (4) ISM 10/57 04

## 2930 CERTIFICATE OF DEATH

Reg. Dist. No.

02922

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg</b> c. LENGTH OF STAY IN 1b <b>Life</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Brooklyn Avenue</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg</b> d. STREET ADDRESS <b>Brooklyn Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>Herman</b> Last <b>Camper</b>				4. DATE OF DEATH Month <b>March</b> Day <b>9</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 18, 1892</b>	
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		IF UNDER 24 HRS Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Day Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Gardener</b>		11. BIRTHPLACE (State or foreign country) <b>Caroline Co., Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME (First name not known) <b>Friend</b>				14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Camper</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or date of service)				16. SOCIAL SECURITY NO. <b>217-10-8260</b>		17. INFORMANT <b>Sadie G. Camper, Federalsburg, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Cerebral Hemorrhage</b> <b>422.1</b> DUE TO <b>Arteriosclerotic C. V. Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Hemorrhage &amp; Hemiplegia Rt</b> (c) <b>Jan 6 1959</b>				INTERVAL BETWEEN ONSET AND DEATH <b>5 mos</b> <b>3 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>3-12-1959</b> to <b>Mar 8, 1959</b> , that I last saw the deceased alive on <b>Mar 8, 1959</b> , and that death occurred at <b>4:10 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. E. Lennon</b>				ADDRESS (Street, city or town, state) <b>Federalsburg Md.</b> DATE SIGNED <b>March 11, 1959</b>			
PHYSICIAN'S NAME (Type) <b>W. E. Lennon, M.D.</b>				<b>Federalsburg, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 14, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Federal Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Federalsburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Frampton and Son, Federalsburg, Maryland</b>				24a. REC'D BY REGISTRAR <b>MAR 17 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

STATE OF CALIFORNIA  
DEPARTMENT OF HEALTH

OFFICE OF THE STATE HEALTH OFFICER  
1001 CALIFORNIA STREET, SACRAMENTO, CALIF. 95833



2931

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Concord</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Concord</u>		c. LENGTH OF STAY IN 1b <u>20</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Concord md</u>	
3. NAME OF DECEASED (Type or print) First <u>Milton</u> Middle <u>E</u> Last <u>Jackson</u>		4. DATE OF DEATH Month <u>3</u> Day <u>3</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cel</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-14-04</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	9. AGE (In years last birthday) <u>55</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Vienna md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Thomas Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Flora Pinkett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Margaret Jackson</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>526X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Bronchiectasis and emphysema</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Left lung removed 1954 for severe bronchiectasis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u> <u>5 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Sept 53</u> to <u>Mch 3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>March 3</u> , 19 <u>59</u> , and that death occurred at <u>7:30A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>E. Paul Knotts</u> M.D. <u>Denton, Md</u>			
PHYSICIAN'S NAME (Type) <u>E. Paul Knotts M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial - B-7-59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Concord Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Concord md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Brooks M. West</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>MAR 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02924

2932

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greensboro</b>		c. LENGTH OF STAY IN 1b <b>4 Months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Collins Nursing Home</b>		d. STREET ADDRESS <b>None</b>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>A.</b> Last <b>Mitchell</b>		4. DATE OF DEATH Month <b>3</b> Day <b>25</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/24/1879</b>
9. AGE (In years last birthday) yrs. <b>80</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard Blackburn</b>		14. MOTHER'S MAIDEN NAME <b>Annie Lowe</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Howard Thomas</b>		Address <b>Bridgetown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Renal Disease</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 1</b> , 19 <b>58</b> , to <b>March 25</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>March 24</b> , 19 <b>59</b> , and that death occurred at <b>7:50 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Greensboro, Md.</b> DATE SIGNED <b>3/27/59</b>			
ACTUAL SIGNATURE <b>Charles H. Stonesifer</b> M.D.		DATE SIGNED <b>3/27/59</b>	
PHYSICIAN'S NAME (Type) <b>Charles H. Stonesifer, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/2 8/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Greensboro</b>		22d. LOCATION (City, town, or county) (State) <b>Greensboro, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Baileys</b>		ADDRESS <b>Greensboro, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>MAR 30 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	



1. PLACE OF DEATH a. COUNTY <b>CAROLINE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CAROLINE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DENTON</b>		c. LENGTH OF STAY IN 1b <b>life</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>GEORGE HENRY MURRAY</b>		4. DATE OF DEATH <b>MAR 27, 1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 2, 1880</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jennio Murray</b>		14. MOTHER'S MAIDEN NAME <b>Mary Catherine Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Not</b>		16. SOCIAL SECURITY NO. <b>0</b>	
17. INFORMANT <b>Margaret Murray Denton, Ind.</b>		Address <b>Denton, Ind.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Heart Disease</b> <b>592X</b> DUE TO (b) <b>Nephritis Chronic</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) <b>6 mos</b> <b>6 mos</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>1P</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Dawson D. George</b>		DATE SIGNED <b>3-30-59</b>	
EXAMINER'S NAME (Type) <b>Dawson D. George</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Mar 30, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Spring Grove</b>	22d. LOCATION (City, town, or county) (State) <b>Denton, Ind.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank McComb</b> ADDRESS <b>Denton</b>		24a. REC'D BY REGISTRAR <b>APR 2 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur A. Thomas</b>

MEDICAL CERTIFICATION

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK  
IN SENATE  
JANUARY 10, 1901.

REPORT OF THE  
COMMISSIONER OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE  
MAY 1, 1899.

ALBANY: J. B. LIPPINCOTT & COMPANY, PRINTERS.  
1901.

THE LAND OFFICE OF THE STATE OF NEW YORK  
HAS THE HONOR TO ACKNOWLEDGE THE RECEIPT OF  
THE REPORT OF THE COMMISSIONER OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE  
MAY 1, 1899.

AND TO TRANSMIT THE SAME TO THE SENATE  
FOR THE CONSIDERATION OF THE COMMITTEE ON LANDS  
AND MINES.

IN WITNESS WHEREOF, THE COMMISSIONER OF THE LAND OFFICE  
HAS HEREUNTO SET HIS HAND AND SEAL OF OFFICE  
AT ALBANY, NEW YORK, THIS 10TH DAY OF JANUARY, 1901.

JOHN W. ALLEN, Commissioner of the Land Office.

ALBANY, NEW YORK.

THE SENATE OF THE STATE OF NEW YORK  
HAS THE HONOR TO ACKNOWLEDGE THE RECEIPT OF  
THE REPORT OF THE COMMISSIONER OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE  
MAY 1, 1899.

AND TO TRANSMIT THE SAME TO THE SENATE  
FOR THE CONSIDERATION OF THE COMMITTEE ON LANDS  
AND MINES.

IN WITNESS WHEREOF, THE SENATE HAS HEREUNTO SET  
ITS HAND AND SEAL OF OFFICE AT ALBANY, NEW YORK,  
THIS 10TH DAY OF JANUARY, 1901.

JOHN W. ALLEN, Commissioner of the Land Office.

02926

2934

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Ridgely</u>				c. LENGTH OF STAY IN 1b <u>10 Years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Gertrude's Convent</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sister Mary Christina Neueier, O.S.B.</u>				4. DATE OF DEATH Month Day Year <u>3-8-1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-29-1897</u>		9. AGE (In years last birthday) yrs. <u>61</u>	IF UNDER 1 YEAR: Months Days Hours Min.	IF UNDER 24 HRS: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew Neueier</u>				14. MOTHER'S MAIDEN NAME <u>Marie Probst</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT Address <u>St. Gertrude's Convent Ridgely, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC LYMPHATIC LEUKEMIA</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (d) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <u>SEVERAL</u> <u>YEARS</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>October 1, 1957</u> , to <u>March 1, 1959</u> , that I last saw the deceased alive on <u>March 1, 1959</u> , and that death occurred at <u>5:35 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles H. Winnacott M.D.</u>				ADDRESS (Street, city or town, state) <u>Ridgely, Md.</u> DATE SIGNED <u>3-8-59</u>			
PHYSICIAN'S NAME (Type) <u>CHARLES H. WINNACOTT</u>				<u>Ridgely, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-11-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Gertrude's</u>		22d. LOCATION (City, town, or county) (State) <u>Ridgely Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J. E. Bouclair &amp; Greensboro Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 12 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

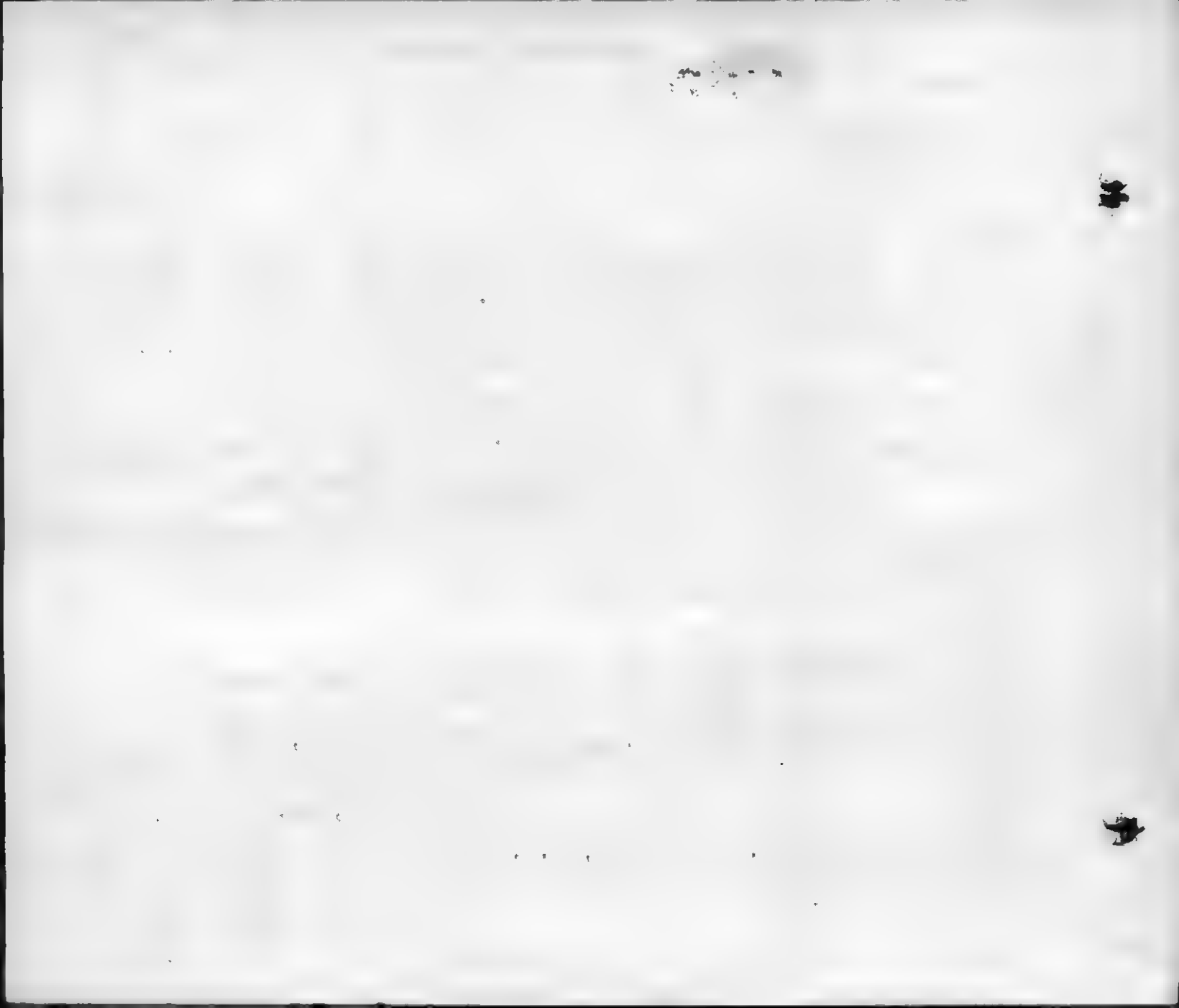
CERTIFICATE OF DEATH

2935

02927  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Henderson</u>				c. LENGTH OF STAY IN 1b <u>38 Yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>				e. STREET ADDRESS <u>None</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Ann</u> Last <u>Phillips</u>				4. DATE OF DEATH Month <u>3</u> Day <u>25</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3.7.1882</u>		9. AGE (In years last birthday) yrs. <u>76</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Rash</u>				14. MOTHER'S MAIDEN NAME <u>Lizza Edge</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-20-7282B</u>		17. INFORMANT <u>Mrs. Charles Nichols Greensboro, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the colon with metastasis to liver and spine</u> DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>  </u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 15, 1958</u> to <u>March 25, 1959</u> , that I last saw the deceased alive on <u>March 25, 1959</u> , and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Greensboro, Md.</u> DATE SIGNED <u>3/27/59</u>							
ACTUAL SIGNATURE <u>Charles H. Stonesifer</u> M.D.				PHYSICIAN'S NAME (Type) <u>Charles H. Stonesifer, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/29/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greensboro</u>		22d. LOCATION (City, town, or county) (State) <u>Greensboro, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Boulais</u> ADDRESS <u>Greensboro, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2936

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg - Rural</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Near Friendship</b>		e. STREET ADDRESS <b>Near Friendship</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Grace Kaptola Satterfield</b>		4. DATE OF DEATH Month Day Year <b>March 24 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 10, 1877</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Caroline Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>John H. White</b>		14. MOTHER'S MAIDEN NAME <b>Laura Waters</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Mrs. Roland McMahan, Federalsburg, Md., RFD</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <b>Cerebral Accident</b> DUE TO <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>Sys.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Radical Mastectomy (left)</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/16</b> 19 <b>59</b> , to <b>3/24</b> 19 <b>59</b> , that I last saw the deceased alive on <b>3/24</b> 19 <b>59</b> , and that death occurred at <b>3:15 A M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Federalsburg, Maryland 3-26-59</b>			
ACTUAL SIGNATURE <b>Frank M. Anderson</b> M.D.		PHYSICIAN'S NAME (Type) <b>Frank M. Anderson, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>March 26, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hill Crest Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Federalsburg, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Frampton and Son, Federalsburg, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 31 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2937

## CERTIFICATE OF DEATH

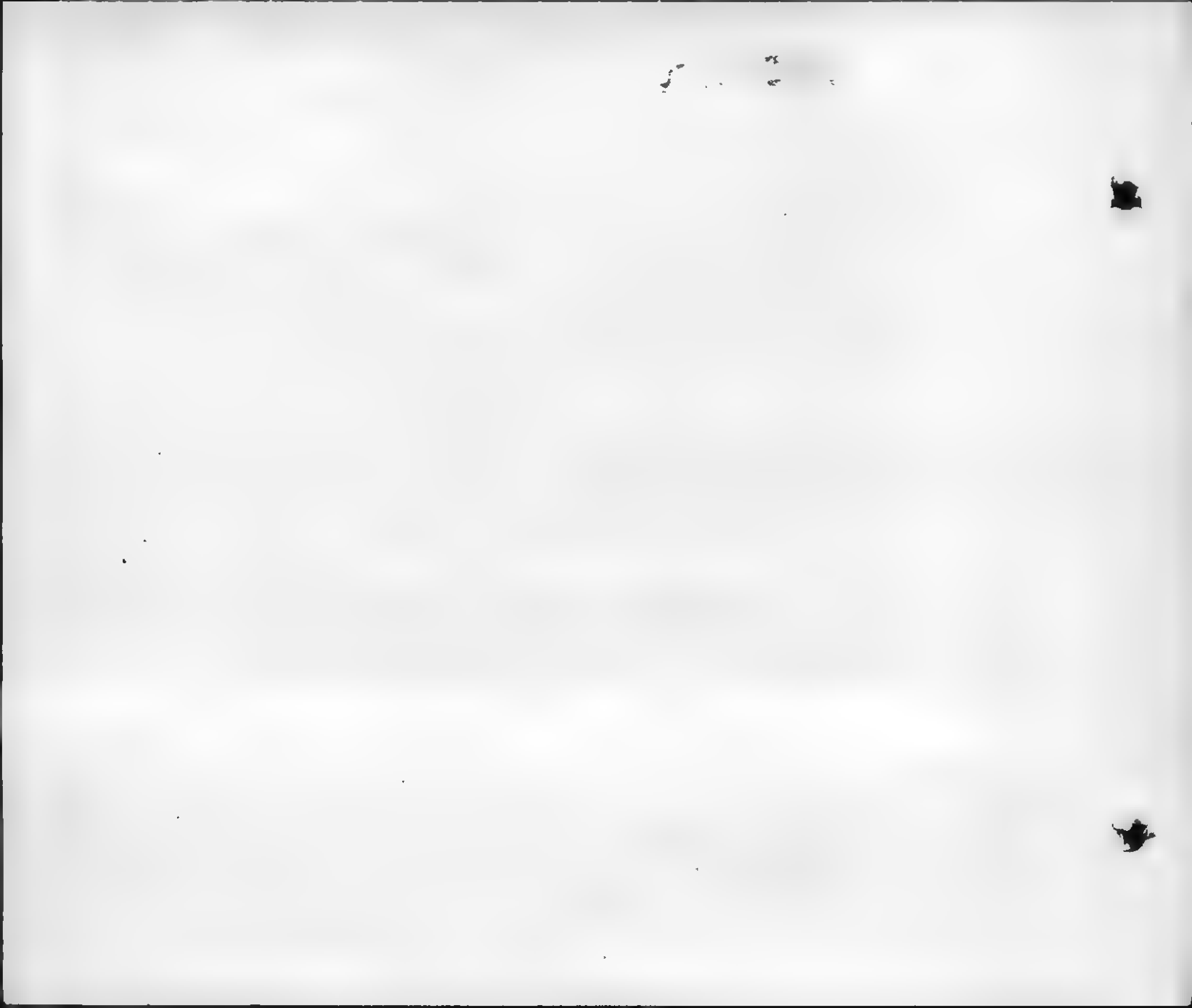
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Preston - Rural</b>		c. LENGTH OF STAY IN 1b <b>40 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Near Friendship</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>Adam</b> Last <b>Schmick</b>		4. DATE OF DEATH Month <b>March</b> Day <b>10</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 25, 1886</b>		
9. AGE (In years last birthday) yrs <b>72</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Former Farm Owner</b>			
11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
13. FATHER'S NAME <b>John Schmick</b>		14. MOTHER'S MAIDEN NAME <b>Marie Sherman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-34-9462</b>			
17. INFORMANT <b>Mrs. Clara A. Schmick, Preston, Md., R.F.D.</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Carcinoma Stomach -</b> <b>11-12</b> DUE TO <b>General Metastasis -</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <b>General Metastasis -</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			INTERVAL BETWEEN ONSET AND DEATH <b>11-18-58</b> <b>3-10-59</b>		
21. I certify that I attended the deceased from <b>11-18</b> , 19 <b>58</b> , to <b>3-10</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Mar 7</b> , 19 <b>59</b> , and that death occurred at <b>6 A. M.</b> from the causes and on the date stated above ACTUAL SIGNATURE <b>W. E. Lennon</b> M. D. <b>Federalburg, Md.</b> ADDRESS (Street, city or town, state) <b>Federalburg, Maryland</b> DATE SIGNED <b>March 11, 1959</b> PHYSICIAN'S NAME (Type) <b>W. E. Lennon, M.D.</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 13, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Junior Order Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Linchester, Maryland</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Frampton and Son, Federalburg, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 17 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 1 Film G240 3-18-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Denton</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Denton</u>	
c. LENGTH OF STAY IN 1b <u>1 yr</u>		d. STREET ADDRESS <u>Daughter's home</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>FRANCES</u> Last <u>SMITH</u>		4. DATE OF DEATH Month <u>MAR.</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 9, 1879</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>house</u>	11. BIRTHPLACE (State or foreign country) <u>Delaware</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Charles Carlisle</u>	
14. MOTHER'S MAIDEN NAME <u>Lina Donovan</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>not</u>	
16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Mrs. Kella Anthony, Denton, Md</u> Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerosis General</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchitis Chronic</u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Dawson O. George</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dawson O. George</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Mar. 11, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hollywood</u>	22d. LOCATION (City, town, or county) (State) <u>Harrington, Del.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Virgil Woodson, Denton, Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 13 '59</u>	
ADDRESS <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>William L. Hanna</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



2939

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u> c. LENGTH OF STAY IN 1b <u>30 yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u> d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CATHERINE BRENNEMAN SWING</u> First Middle Last			4. DATE OF DEATH <u>March 21</u> 19 <u>59</u> Month Day Year		
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 30, 1897</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cow Home</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
13. FATHER'S NAME <u>John Breneman</u>			14. MOTHER'S MAIDEN NAME <u>Minnie Frank</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>John Thompson Swing</u> Address <u>Ridgely, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>HYPERTENSIVE CEREBROSCLEROTIC HT. DS.</u> <u>443X</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebrosclerosis, Generalized</u> DUE TO (c) <u>10 years -</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>April 1947</u> to <u>March 21, 1959</u> , that I last saw the deceased alive on <u>March 21, 1959</u> , and that death occurred at <u>5:45 P.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Charles H. Winnacott</u> M.D.		ADDRESS (Street, city or town, state) <u>Ridgely, Md</u>		DATE SIGNED <u>3.24.59</u>	
PHYSICIAN'S NAME (Type) <u>CHARLES H. WINNACOTT - Ridgely, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Mar 25-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Deaton</u>	22d. LOCATION (City, town, or county) (State) <u>Deaton Md</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Thoma</u>		ADDRESS <u>Boston Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 26 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>

# CERTIFICATE OF DEATH

State of New York

County of \_\_\_\_\_

City of \_\_\_\_\_

Decedent's Name \_\_\_\_\_

Age \_\_\_\_\_

Sex \_\_\_\_\_

Marital Status \_\_\_\_\_

Occupation \_\_\_\_\_

Place of Birth \_\_\_\_\_

Date of Birth \_\_\_\_\_

Place of Death \_\_\_\_\_

Date of Death \_\_\_\_\_

Time of Death \_\_\_\_\_

Cause of Death \_\_\_\_\_

Manner of Death \_\_\_\_\_

Signature of Physician \_\_\_\_\_

Signature of Coroner \_\_\_\_\_

Signature of Registrar \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

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Signature of \_\_\_\_\_